STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

A. The following charges are imposed on the categorically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR §447.53.

Service *	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions	-0-	-0-	$1.00	State's average per script of $18 is used as payment basis.
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this Attachment.

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B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he/she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

   a. Placing the patient's health in serious jeopardy;

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.